COORDINATED ASSESSMENT:
PENDING DECISIONS - *PRIORITY 2 FHH*

Reviewed by SSFF 1/6/15, continued 2/4/15, 4/7/15, 5/5/15, & 6/2/15

VI-SPDAT/SPDAT Issues and Use

- When do we finalize scoring ranges drafted 10/13 & proposed 1/14 (below)?

	ES only	RRH	TH	PSH
Family VI-SPDAT Prescreen v2.0	0-3	4-6	7-8	9+
F-SPDAT Assessment	0-26	27-39	40-53	54-80
VI-SPDAT (non-veterans)	0-4	5-9		10+
VI-SPDAT (veterans)	0-1	2-6	7-9	10+
SPDAT Assessment	0-19	20-39		40-60

Due to the resource allocations, the Family VI-SPDAT scoring ranges will be used as a guideline for veteran-specific resources. Veteran-specific PSH will be reserved for the highest acuity families, and GPD (TH) and SSVF (RRH) will be used flexibly to serve low to moderate acuity families.

It is feasible that families scoring for PSH may need access to lesser interventions (ES, TH,RRH) until an appropriate PSH unit is available. In these cases, the lesser intervention will be considered "bridge housing."

Housing Match and Placement Criteria (Eligibility)

What is an acceptable acceptance/denial rate for participants? If they are offered space in a program and they decline, what happens? In which circumstances are they offered them space in a different program?

When possible, we will attempt to accommodate family size and geographic preferences for work and school.

For emergency shelter, once determined that a family is eligible and able to enter any program for which they qualify, declining shelter will remove them from the SPL for 30 days. If they wish to be placed back on the SPL, they will need to return to the FHH.

For Rapid Rehousing, if a client declines services they will be removed from the SPL. If they wish to reapply they must return to the FHH. Because RRH is similar regardless of service provider, clients will have choice in where they live but not in the agency providing the service.

Clients wishing to reconsider Rapid Rehousing that are eligible, will be placed on the bottom of the list.

For transitional programs, families are notified at time of assessment all info regarding program amenities, location, costs, and wait lists. Families are asked to select one program and are placed on the SPL. If a family declines the program they are signed up for, they will be removed from the SPL. Clients wishing to reconsider TH will need to go back to the FHH and will be placed at the bottom of the SPL.

A family on a transitional housing list may choose to be placed on a list for a different TH provider by going to the FHH and notifying the SPS. Any changes must be approved by the SPS's Coordinator.

For Permanent Supportive Housing, families declining PSH will be removed from the SPL. Families wishing to reconsider PSH, will need to return to the FHH and will be placed on the list in order of acuity score on the full FSPDAT.

In all cases the Family Housing Hub staff must provide clear and complete informed consent so that families are fully aware of all options and consequences.

According to recommendations from OrgCode, a Family-VISPDAT will only be completed every 6 months or in the circumstance of a major life changing event such as death of a family member. If a new score is determined, families that have declined previous interventions will be placed on the SPL for the new intervention with the new assessment date.

Families will be told at time of assessment that they will be removed from lists if declining service. If the FHH learns of a family declining services and the family is in emergency shelter, the FHH will notify the emergency shelter prior to removing them from the list.

We are implementing a modified progressive engagement strategy. The Family VI-SPDAT score determined by the staff at the FHH will determine the initial intervention for the family. In the event that this intervention is not successful and the still homeless family returns to the FHH with a full assessment score from an F-SPDAT trained provider agency that substantiates the need for a higher level of service, the family will be routed through the established procedures for accessing that intervention.

Geography and Integration with Other Service Systems

How will we implement East and West valley access points? Fixed sites? Mobile outreach teams? How will we solicit proposals? How will decisions be made? Based on what? How to secure funding?

Based on the data that has been collected since August 2014, there is not enough substantiated need to open full service sites in the East and West valley. For at least the remainder of the first year of operation (through August 2015), we will send Family Housing Hub staff to East and West valley locations to conduct assessments weekly. All forms, procedures, data systems, and homeless resources used at any of the sites will be identical. The only variance for the East and

West valley locations will be days and hours of operations and local non-homeless resource information, which may be customized based on geographic location.

Who is mandated to participate in the coordinated assessment system? Programs funded by the CoC, ESG, VSUW, DES? What does participation mean? When will they be held accountable for fully participating in the system?

Current contracts for homeless services with the City of Phoenix, HUD Continuum of Care, VSUW, and DES require participation in the coordinated assessment system.

HUD CoC: To use the centralized or coordinated assessment system established by the Continuum of Care as set forth in § 578.7(a)(8). A victim service provider may choose not to use the Continuum of Care's centralized or coordinated assessment system, provided that victim service providers in the area use a centralized or coordinated assessment system that meets HUD's minimum requirements and the victim service provider uses that system instead;

VSUW: VSUW requires that agencies utilize the Homeless Information Management System, participate in the Coordinated Access and Assessment System and follow the policies, procedures and measurements as facilitated by the Continuum of Care.

DES: 4.2 Participate in the Coordinated Assessment System, when available, for the Continuum of Care in which the Contractor participates.

For the FY2014 NOFA process, the CoC defined participation as:
What it means to participate in the Regional Coordinated Assessment System:

- 100% of the project referrals will come from the regional coordinated assessment system. (i.e., housing list managed by the UMOM Family Housing Hub, or the housing placement list managed by the Campus Welcome Center) per the timeline established by the UMOM Family Housing Hub and/or the Campus Welcome Center.
- The project will notify the appropriate access point when there is a vacant unit.
- The project will make programmatic adjustments to accommodate individuals and/or families in the scoring range for the intervention.
- The project will provide transparency with the CoC and the CoC-approved Coordinated Assessment access points, particularly if the agency has plans to open or close programs, change capacity, or shift resources from one intervention to another.
- The project will use the full SPDAT and/or F-SPDAT as a case management tool.
- The project will Implement the CoC approved Standards of Excellence.
- Attending meetings of the Standing Strong for Families and/or HEART group.

How will the access points integrate with the CRRC?

Veteran specific FHH staff will work directly with CRRC to receive referrals of veteran households who need homeless resources. In addition, veteran specific staff will work directly with the CRRC to determine VA eligibility of all veterans.

Are there other special populations or systems to create or coordinate with (ex: Youth, SMI/RHBA, Other Institutional Providers)

The FHH will provide screening and assessment for youth age 18-24 with minor children and will integrate youth resources specific to youth with minor children. When the Transition-Aged Youth VI-SPDAT is available, it will be used to assess this population.

The FHH will provide screening and assessment for ABC housing for SMI households with minor children beginning in March 2015. The FHH will also work with other family providers that offer SMI specific resources. SMI households will be prioritized for those resources.

The FHH will provide screening and assessment for pregnant women with substance use issues and work with the network of community-based providers to ensure referrals are made expeditiously.

Standing Strong For Families recommends that the CoC Board consider making accommodations for behavioral health providers.

The FHH will provide screening and assessment for individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim service providers. The FHH will adhere to any and all policies established by the Maricopa County Continuum of Care.

Options for coordination with the domestic violence coordinated entry system, HUD Multifamily Housing Program, HUD Section 8 program, Low Income Housing Tax Credit projects, and Mercy Maricopa Integrated Care (MMIC) will be explored in 2015.

Service Standards/Placement Follow Through

How do we ensure strong "warm" hand-off? How long is CA system involved through housing?

Navigation will primarily take place in the emergency shelter. Emergency shelter case managers will work with the FHH to determine what is needed for the household to enter housing and will assist the family with identifying a plan. Veterans will be navigated in conjunction with the SSVF case managers and CRRC.

Are all HUD funded agencies expected to utilize SPDAT as ongoing case management tool for housing based case management?

To date, this has not been included in the contracts by the funders. We believe use of the evidence-based FSPDAT as a case management tool, consistently applied among service providers within the system would improve the overall performance of the system. It is a more comprehensive assessment tool than the Arizona Self-Sufficiency Matrix. The FSPDAT helps to focus services on exits to permanent housing. The more effective the service providers are at ending homelessness, the fewer families who will repeatedly need to access homeless services.

The full assessment scores are also important to the progressive engagement strategy. In the event that the initial intervention does not end the family's homelessness, a full F-SPDAT score

is an important tool in determining the most appropriate next steps for assigning an intervention.

System Infrastructure

What are the baseline outcome measures for the community based on HEARTH and how do we measure progress?

The community will begin to collect baseline data once all of the programs are participating in coordinated assessment through the Family Housing Hub. We anticipate beginning this data collection process by June of 2015.

As the technology becomes available through HMIS and decisions are recommended by the Performance Standards and Data Quality working group and approved by the CoC Board, the following HEARTH outcomes will be measured, reported, and used to document progress:

- Reduction in length of time homeless
- Reduction in recidivism (subsequent return to homelessness)
- Increase in access/coverage (thoroughness in reaching persons who are homeless)
- Overall reduction in number of persons who experience homelessness
- Increases in job and income growth for persons who are homeless
- Reduction in number of people experiencing homelessness for the first time

What are the technology solutions for coordinated assessment? Does HMIS/Bowman have the capacity to do everything we need? Do we need an additional database for matching functionality?

HMIS is being used for the following purposes:

a. Entry/exits for Family Housing Hub
b. Collection of Universal Data Elements
c. Storage of critical documents
d. File sharing with receiving agencies
e. Tracking of Family VI SPDAT scores *(when available in HMIS)*

An Access database has been developed for the following purposes:

f. Collecting program eligibility information
g. Matching of family to program
h. Tracking of Service Priority Lists for each housing and shelter intervention
i. Documenting family journey from shelter to housing intervention

Do we need formal data sharing agreements so that the information flows from the access points to the provider(s) working with the participants? What elements will be shared? With whom? For what purpose? How do we consistently provide quality informed consent?

Release of information will be initiated at the FHH.

First level of information will be basic eligibility and demographic information on shared SPL for emergency shelter or one page referral for TH, RRH, and PSH.

Second level of information will be shared once client is confirmed for program entry. This information may include: Family VISPDAT (of FSPDAT for PSH), vital docs for all family members, income verification/ certification, HMIS entry/ exit information, and information regarding any SPL that household may be on including any info necessary to assist client in obtaining permanent housing.

Third level of information will be shared once family is in program (primarily emergency shelter) to provide ongoing info regarding wait list status and information related to assisting client in obtaining permanent housing.